Schmieding /ILC Solutions Forum on Elder Caregiving

June 2, 2005 ♦ 9 am -12 noon

Schmieding Conference on Elder Homecare

June 2, 2005 ♦ 12 noon - 4 pm

REPORT OF FINDINGS

JERRY L. MITCHELL
HOW GOVERNMENT CAN IMPROVE IN-HOME ELDERCARE

HOW GOVERNMENT CAN IMPROVE IN-HOME ELDERCARE

SOLUTIONS FOR KEEPING ELDERS AT HOME FOR LIFE

TESTIMONY OF JERRY L. MITCHELL TO THE POLICY COMMITTEE OF THE WHITE HOUSE CONFERENCE ON AGING

My name is Jerry L. Mitchell. I am the Executive Director of the Area Agency on Aging of Northwest Arkansas and the President of the Aging Foundation. The Agency is a non-profit agency. I am a native of North Arkansas. I graduated from Harvard University with a Master of Public Administration and also hold a Master of Science degree from Arkansas State University. I served on active duty in the Army and retired from the United States Army Reserves as a Lieutenant Colonel. I have twice served as the past president of the Arkansas Association of Area Agency on Aging and also have also served as a member of the Governor's Advisory Committee on Aging.

SUMMARY OF FINDINGS

I have been asked today to present solutions that the government can use to improve in-home eldercare. Thank you for allowing me this opportunity to present. I was recently given a report that was taken from the State of Aging and Health in America 2004, by Merk Institute on Aging and Health. The report stated that starting in 2012, nearly 10,000 Americans will turn 65 every day. That is only six and one half years from now! The report went on to say that the average 75 year old has three chronic conditions and uses five different drugs. You can see from these statistics that Gray is in and that we are in an emerging industry. The state of Arkansas offers both home and community based services and institutional services to the low-income elderly. Partnering with the federal government, the state offers several ways to keep low-income elderly in their homes as long as possible. Arkansas' Division of Aging and Adult Services has been innovated in applying for and receiving funding that has allowed the state aging network to test models that may later be a part of waiver services funded by Medicaid. The Medicaid waiver allows some low-income seniors to receive an array of services that they would not normally receive. It is often perceived by the in-home providers and the in-home clients that the playing field is not level for in-home services versus institutional care. The most common complaints that are often heard is that the waiver services do not provide the same level of care and that funding is not equal, that many seniors are not allowed into some of the in-home programs early enough, and that the in-home care system is not flexible enough to accommodate the client.

RECOMMENDATIONS AND REFORMS

It can often be shown that allowing a person to age in a home and community based setting is far more economical in the long run than pre-mature institutionalization. Since government budget cycles are fixated on the next fiscal year, it is very difficult to get lawmakers to make an investment on long-term savings. It is extremely difficult to change public policy to have more governmental funding directed to saving tax dollars in future years. I remember vividly the advice that the foreman for the construction company who was building our office complex gave to me when I came to him with a question if something could be done differently than what was shown on the blueprint. His advice was "It's a function of dollars". Many of the problems that we have with in-home care for the elderly could be solved if we had more money for the programs. The difference between income and expenses is marginal in the in-home care business. One of the major problems for the in-home care providers is the inability to hire and retain adequate staff. If the Medicaid re-imbursement rate for in-home care attendants were equivalent to the re-imbursement for nursing home attendants then, in-home care providers would be able to recruit and retain in-home care staff.

Many potential in-home care attendants have little or no formal training. They are also without adequate resources to pay for the training that is required to be certified to hold the position. Since this is a nationwide problem, there should be a cooperative effort between the Department of Labor and Health and Human Services to offer incentives to in-home service employers to recruit and retain these laborers. There should also be a monetary incentive to the person that is willing to be trained and enter the in-home care career field. Many in-home clients need more hours in their care plans and greater flexibility in the care plan but waiver restrictions and again, lack of staff prevent them from getting the care that they need. Often this lack of care causes the client's condition to deteriorate to the point that they have to enter an institution or worse yet, die. There are also other ways to address the money issue. One method would include a system that allows the money to follow the person when the person has been in an institution and wants to return to the home and community based service network. The person would then be allowed to spend a comparable amount to purchase home and community based services. Another method would be for a more structured use of cash and counseling that closely monitors the client to assure that specific outcomes are being achieved that fit with the care plan. All care plans should have a care path as an integral part of them and this should tie to a disease management track that will address all of the client's illness rather than one specific disease.

Clients often find that getting into a waiver program takes a long time, the care plan that is developed for them is inflexible or they fail to be informed about the in-home care option until it is to late. There is merit to having a long-term care system that requires a potential Medicaid eligible elderly person to be informed of the choices available to them. This could be done directing the elderly person through a one-stop office at the Division of Aging and Adult Services or by service providers being required to provide the potential client with factual literature that details the options that are available to them in both the home and community as well as institutional care. A publicity campaign could be used to make sure persons were aware of the point of entry. Service providers in the aging network could be educated on counseling the elderly on the services available and held accountable for making sure that the client was briefed on the long-term care options available. All of the client's stakeholders should be involved in the planning process as early as possible. This team would include caregivers, family, doctors, service providers, case managers, etc.

To assure continuity, a care plan should be developed for the client. Care plans developed for in-home care should be flexible enough to address what the person needs rather than be task specific to be performed for them. There needs to be more interface between the social services and the medical services for care plans to accomplish this goal. The State of Georgia has a Medicaid waiver that is evidence based where this is working successfully and has some reported cost savings. Case managers have the authority to work directly with the doctors and make changes to the care plan as the conditions of the client warrant the change. All plans have care paths and are centered on disease management. This method will shorten hospital stays, reduce emergency room visits and lower the percentage of elderly that are going to nursing homes. It will also supply a safety net for those patients that have completed their rehabilitation in the nursing home and need to return to the home and community based setting. This team approach is something that is lacking in Arkansas and many other states unless more expensive models like PACE is used.

More emphasis should be put on developing models for the elderly that are just above the poverty threshold. Most of this group will go through a spend-down process and will enter the government long-term care support system, especially if they have chronic disease and/or must receive institutional care. By getting these people into programs that emphasize healthy aging and make them aware of long-term care needs, the state and federal government will save money and their quality of life can be improved as well. Current in-home care programs provide little financial protection to the spouse of the patient as compared to institutional care. Smart economics show that it would be better to not impoverish the spouse while the patient gets care. When the spouse becomes destitute, this causes them to not be able to live healthy and they enter the program at an earlier period. This just forces the government to take two for the price of two instead of just having one. Again leveling the field and adjusting the poverty threshold would make more sense.

In summary, the processes that I have recommended are not revolutionary. Changes in the in-home care services for the elderly do not have to be revolutionary but some changes do need to be made by the government. The playing field in funding and access for services for in-home care for the elderly versus institutional care needs to be leveled. It is hard to change the direction that in-home care has been going so long. It is like a big ship that takes a lot of room to turn around but it can be turned. Thank you again for allowing me to present.